



# Claim Form

Senior Life Insurance Company

P.O. Box 2447

Thomasville, GA 31799-2447

1-877-777-8808

A Georgia Stock Company • Executive Offices: Thomasville, Georgia

## AUTHORIZATION – MEDICAL INFORMATION FOR FILING A DEATH CLAIM

"I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility or insurance company that has any records or knowledge of the deceased or the deceased's health to give to the Claims Department of Senior Life Insurance Company or its reinsurers any such information including mental, alcohol, drug or HIV (Human Immunodeficiency Virus) related information for the purpose of assessing the pending claim. This authorization may be used for the duration of the pending claim. I may request and receive a copy of any medical information obtained with this authorization. A photostatic copy of this authorization shall be as valid as the original. I declare that I am of legal age to file this claim."

Name of Deceased \_\_\_\_\_

Next of Kin (print name) \_\_\_\_\_

Policy # \_\_\_\_\_

Street Address \_\_\_\_\_

Relationship to Deceased \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If death has occurred within 2 years of issue/reinstatement date or if the death was by Accidental means, list the doctors/hospitals that treated the insured in the **5 years prior to the application date.**

Primary

Doctor \_\_\_\_\_

Doctor \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Hospital \_\_\_\_\_

Clinic \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

**X** \_\_\_\_\_  
Signature of Next of Kin

**PLEASE COMPLETE THE APPROPRIATE INFORMATION ON REVERSE SIDE OF THIS FORM.**

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**BENEFICIARY INFORMATION**

Name of Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**ASSIGNMENT OF PROCEEDS OF INSURANCE**

I, \_\_\_\_\_, being entitled to receive benefits under Policy # \_\_\_\_\_  
(Beneficiary)

issued by Senior Life Insurance Company on the life of \_\_\_\_\_,  
(Deceased/ Insured)

now deceased, and having contracted with and being indebted to \_\_\_\_\_  
(Funeral Home)

of \_\_\_\_\_ for funeral services and merchandise for the deceased, do  
(Address, City, State, Zip)

hereby set over, assign and transfer unto said Funeral Director the sum of \_\_\_\_\_

Dollars (\$ \_\_\_\_\_) out of the proceeds of said Insurance Policy; and I hereby authorize and direct

Senior Life Insurance Company to make its check payable to said Funeral Director for the assigned amount and to pay the remainder of the proceeds of said Insurance Policy, if any, to me.

\_\_\_\_\_  
(Beneficiary Signature)

\_\_\_\_\_  
(Beneficiary Signature)

**NOTARY  
SEAL**

Sworn and subscribed before me the \_\_\_\_\_ day of \_\_\_\_\_,

NOTARY PUBLIC \_\_\_\_\_ My commission expires \_\_\_\_\_

**AFFIDAVIT FOR LOST POLICY**

I, the undersigned, hereby certify that Policy # \_\_\_\_\_ issued on the life of \_\_\_\_\_ by the Company has been lost or destroyed.

Beneficiary Signature \_\_\_\_\_

Date \_\_\_\_\_

**BENEFICIARY CERTIFICATION**

Checklist:

Certified Death Certificate  Original Policy/Affidavit for Lost Policy  Claim Form  HIPAA Form

By signing below I, the Beneficiary, certify that the statements in this form are true to the best of my knowledge and that all necessary paperwork has been completed according to the above checklist.

Beneficiary Signature \_\_\_\_\_

Date \_\_\_\_\_

Beneficiary Signature \_\_\_\_\_

Date \_\_\_\_\_